BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
FRED WILLIAM WAKIL, M.D.	)	**Case No. 800-2016-026609**
Physician's and Surgeon's Certificate No. G 49172	)	**OAH No. 2018020889**
Respondent	)	

DECISION AND ORDER

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 12, 2018.

IT IS SO ORDERED September 13, 2018.

MEDICAL BOARD OF CALIFORNIA

By: _____

Kristina D. Lawson, J.D., Chair
Panel B

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PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on July 15-19, 2018, in Oakland, California.

Joshua M. Templet, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Jane Luciano, Attorney at Law, Luciano Health Law, represented respondent Fred William Wakil, M.D., who was present.

The record closed and the matter was submitted for decision on July 19, 2018.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs (Medical Board).

2. On October 25, 1982, the Medical Board issued Physician's and Surgeon's Certificate (Certificate) No. G 49172 to respondent Fred William Wakil, M.D. Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on August 21, 2018, unless renewed.

Summary of case

3. The Accusation alleges that respondent committed repeated acts of negligence and gross negligence while providing treatment to two patients (P1 and P2),[1] in the Emergency Department (ED) at St. Joseph's Hospital (St. Joseph's) in Eureka. Respondent filed a notice of defense and this hearing followed.

In the case of P1, it is alleged that respondent failed to prioritize imaging of an acute arterial occlusion and update the hospitalist regarding P1's evolving symptoms of acute ischemia in P1's leg; and, that he failed to obtain a vascular surgery consult when an ischemic limb was suspected. It is also alleged that respondent committed unprofessional conduct when he failed to document his physical examination of P1 and medical decision-making in P1's medical record. In the case of P2, it is alleged that respondent failed to recognize numerous signs of acute organ dysfunction and impairment which were consistent with a significant decompensation of congestive heart failure and required acute hospitalization or consultation; and, instead, respondent based his treatment of P2 entirely on P2's respiratory response to furosemide.

Expert testimony at hearing

4. The experts who testified at hearing were familiar with the standard of care applicable to the professional conduct of ED physicians in California. Each expert reviewed pertinent medical records and documents, as well as respondent's interview with the Medical Board on June 28, 2017. They each offered an opinion as to whether respondent committed unprofessional conduct in connection with his treatment of P1 and P2. Both physicians defined the standard of care as the skill, knowledge and care that a reasonably prudent ED physician would employ in a similar situation.

MEDICAL BOARD EXPERT

5. David Arnold Schumb, M.D., graduated from the University of California, Irvine, Medical School, in 1985. Dr. Schumb completed two residencies at Highland General Hospital, in Oakland: he completed his first residency in 1989, in internal medicine, and his second residency in 1993, in emergency medicine. Dr. Schumb is Board-certified by the American Board of Internal Medicine and the American Board of Emergency Medicine. He has worked in a number of ED's in the Bay Area. For about the last 10 years, Dr. Schumb has worked at Kaiser Permanente. Currently, Dr. Schumb holds three positions at Kaiser: he is a member of the Peer Review Committee and the Emergency Prospective Review Program, and he provides emergency room services at two of Kaiser's ED's. Dr. Schumb is also a medical reviewer for the Medical Board.

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[1] The patients are referred to as P1 and P2 to protect their privacy.

RESPONDENT'S EXPERT

6. Alexander M. Lam, M.D. graduated from Harvard Medical School in 2004, and completed an emergency medicine residency at Boston Medical Center. He is Board-certified in emergency medicine, and has been licensed to practice medicine in California since 2008. Dr. Lam is a partner in San Francisco Emergency Medical Associates, which staffs ED's with emergency medicine physicians. Dr. Lam is a full-time attending emergency physician at California Pacific Medical Center (CPMC) campuses; he provides emergency care on a part-time basis at Sutter Santa Rosa Regional Hospital (Sutter). Dr. Lam is also the Medical Director of CPMC's Davies Campus, and performs quality assurance reviews at four of CPMC's campuses and two of Sutter's campuses.

Respondent's background

7. Respondent received his medical degree from the University of Wisconsin in 1981. He completed an internship in 1982 and a residency in 1984, in emergency medicine, at the University of Southern California Medical Center. Respondent has been Board-certified in emergency medicine since 1990. He has worked in the field of emergency medicine for his entire medical career, which has spanned about 35 years. During his career, he worked at trauma centers and community hospitals. Respondent's last position as an emergency room physician was at St. Joseph's Hospital, where he worked until September 2016. Since leaving St. Joseph's, respondent has been writing a book about emergency room medicine, which he hopes to have published next year; and he has also completed over 264 hours in continuing medical education. Respondent is passionate about the field of emergency medicine.

8. This is respondent's first disciplinary matter before the Medical Board.

Credibility finding

9. Respondent's testimony at hearing was forthright and credible in all respects.

Respondent's treatment of P1

10. P1, a 91-year-old female with a history of chronic low back pain, was brought to St. Joseph's ED by ambulance on June 4, 2016,[2] after she experienced sudden and severe lower back pain while standing and talking to a friend. Respondent was on duty and evaluated P1 at 5:09 p.m. Respondent noted that P1's pain radiated down her right leg and was associated with right foot numbness. Respondent noted that P1's pain was so severe that she was unable to stand. He also noted the presence of paresthesia, without urinary incontinence or saddle anesthesia. Respondent remembers P1 well due to her unusual presentation of symptoms. Respondent ordered narcotic pain and nausea medications to be

[2] Unless otherwise indicated, the events relating to P1 occurred on June 4, 2016.

given intravenously, blood work, and a CT lumbar spine without contrast. His initial assessment was that P1 might be suffering from a "spinal event." After five to 10 minutes, he realized that P1 would need to be admitted to the hospital, and he so informed the hospitalist, Christina Garza, M.D.

11. At 6:01 p.m., P1 had developed paralysis and a loss of sensation in both legs. Her legs, however, were still warm and pink. Respondent became seriously concerned that respondent was suffering from a neurological emergency, specifically, cauda equina syndrome (also referred to as spinal cord compression), and he regarded her condition as critical. Respondent decided to cancel the CT of the lumbar spine and order an MRI of the lumbar spine since it is the "gold standard" for diagnosing cauda equina syndrome. Respondent also left a voicemail for neurosurgeon John Aryanpur, M.D.

12. Respondent reassessed P1 at her bedside at 6:05 p.m., with another ED physician, Dr. Falk. At 6:05 and 6:15 p.m., nursing staff informed respondent that they were unable to find pulses in her legs. Respondent regarded P1's condition as critical, but at the same time, he took into account that "getting Doppler pulses in a 91-year-old can be very difficult." Respondent observed that P1's extremities were still warm and pink. Respondent ordered the MRI of the lumbar spine at 6:14 p.m. At 6:17 p.m. respondent ordered dexamethasone, a steroid. This medication appeared to somewhat improve P1's symptoms and her ability to move her legs.

13. At 6:23 p.m., a nursing note stated that P1's toes were cool to touch. Respondent believes that at this time, he assessed P1 and found her leg to be cool and pale.[3] After this finding, respondent widened the possible diagnoses from cauda equina to include an "acute vascular event." Between 6:23 and 6:37 p.m., respondent received a call back from neurosurgeon Dr. Aryanpur and spoke with him about P1's condition. Dr. Aryanpur recommended an MRI of the cervical, thoracic and lumbar spines, as well as a CT angiogram (CTA) of the abdomen to assess for spinal cord infarction. At 6:37 p.m., respondent placed orders for a CTA, to evaluate the possibility of vascular occlusion, and for MRI's, to evaluate the possibility for acute spinal cord emergency. Respondent did not consult with a vascular surgeon after he suspected a possible vascular emergency because he wanted to obtain definitive evidence of a vascular occlusion from the CTA before doing so. Respondent explained that because the availability of consultants is limited in the rural area where St. Joseph's is located, it was customary for emergency room physicians at St. Joseph's to obtain the results of a CTA before calling the vascular surgeon.

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[3] The exact time of respondent's observation is not documented because he did not note this development in P1's medical record. Complainant suggests that respondent made this observation at 7:15 p.m. because nursing notes document that respondent was at her bedside at that time. However, respondent made multiple visits to P1's bedside; and, his testimony at hearing and at his Medical Board interview on June 28, 2017, consistently place this observation as occurring before he spoke with Dr. Aryanpur and before he ordered the CTA and MRI's. Respondent's testimony on this point is found to be credible.

14. As soon as respondent ordered the MRI's and the CTA at 6:37 p.m., respondent fully updated Dr. Garza regarding P1's condition, including that he had widened his possible diagnosis to include the possibility of an "aortic emergency," and that he had spoken with Dr. Aryanpur and ordered additional testing.

15. It was important to respondent that P1 be admitted to the hospital, and he made a request to admit her at 6:45 p.m. According to respondent, at St. Joseph's an ED physician's request to admit a patient to the hospital signals the transfer of management and care of a patient from the ED physician to the hospitalist. Nursing notes at 6:45 p.m. state that Dr. Garza was at P1's bedside for admission following respondent's request to admit. At 6:45 p.m., Dr. Garza took over managing P1, as is reflected by Dr. Garza writing orders for P1's care, and her presence at P1's bedside for admission.[4] Nursing notes at this 6:45 p.m. also reflect that Dr. Garza was concerned about a "spinal cord emergency," and that the MRI screening form was completed.[5]

16. P1 remained in her bed at the ED after Dr. Garza took over managing her care. Respondent checked in with P1, assured her that the necessary tests had been ordered, and verbally updated Dr. Garza regarding her condition. A hospital note at 7:10 p.m. states that respondent told the nurses to take P1 for an MRI before the CTA. Respondent denies giving the nurses instructions regarding the sequencing of the imaging studies. By 7:10 p.m., he was no longer managing P1's care, and since Dr. Garza was actively managing P1, any questions from the nurses regarding the sequencing of the imaging studies should have been directed to her. A nursing note at 7:15 p.m. documented ongoing problems with locating P1's pulses, and also stated that P1's feet were "cool to touch." The note also states that respondent was at P1's bedside at this time.

17. Dr. Garza's history and physical, recorded at 7:20 p.m., notes that P1's "distal pulses [were] faint." Her assessment and plan described the findings as "very worrisome for acute spinal cord injury," and that "STAT MRI spine ordered and CT scan of abdomen to rule out aneurysmal disease."

18. P1 was taken offsite for an MRI at 8:28 p.m. and returned at 11:51 p.m. Shortly after midnight on June 5, following P1's MRI, Dr. Aryanpur evaluated her. In his history and physical report, Dr. Aryanpur notes concerns about the possibility of a "vascular injury of some sort"; however, he also retained spinal cord decompression as a possible diagnosis. He thought that if the CTA was negative, then "we should pursue relatively urgent decompression with L5 laminectomy and L5-S1 discectomy."

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[4] Dr. Garza actually began ordering procedures for P1 at 6:31 p.m., with the exception of respondent's orders for MRI's and a CTA, and one order for a MRSA culture at 7:18 p.m.

[5] The MRI equipment at St. Joseph's was not working, so arrangements were made to transport P1 by ambulance to an imaging facility located minutes from the hospital.

19. After a CTA concluded at about 1:35 a.m., on June 5, P1 was diagnosed with aortic vascular occlusion with paralysis of lower extremities. P1 received emergency vascular surgery, an open aorta bilateral femoral thromboendarterectomy, shortly after 3:00 a.m. On June 5, 2016, intensivist W. Scott Sagemen, M.D. wrote:

> [s]uccessful revascularization of an occluded abdominal aorta. The hardest part is ahead. Patient's age, delay in diagnosis due to an unusual presentation, emergent nature of procedure and multiple comorbidities all contribute to a dramatically increased mortality.

On June 6, P1 developed renal failure. On June 7, P1 had a seizure, which was thought to be secondary to an ischemic event; the family withdrew care, and P1 died.

EXPERTS' OPINIONS

20. Dr. Schumb acknowledged that P1's presentation was "a complicated case with dynamic clinical findings." Dr. Schumb concluded, however, that, respondent's treatment of P1 constituted an extreme departure from the standard of care and was grossly negligent, because no other "reasonable or prudent" emergency physician would have provided such care. Dr. Schumb based his opinion on several factors. First, Dr. Schumb believes that respondent failed to incorporate P1's clinical changes into his evaluation of her potential diagnoses. After P1 entered the ED, she developed paralysis and a loss of sensation in both legs, and nursing staff could not locate pulses in P1's legs. In Dr. Schumb's view, once P1 developed a cold, pale leg, which he believes occurred at 7:15 p.m., her symptoms, taken together, reflected acute signs of limb ischemia consistent with an acute vascular emergency. At this point, Dr. Schumb believes that "a vascular occlusion should have risen to the top of the list." Because an untreated vascular occlusion could result in the loss of a limb or death, time was of the essence; and, because CTA's are the "gold standard" for assessing ischemic occlusion and can be completed in five to 10 minutes, respondent should have obtained a CTA before an MRI. While Dr. Schumb agreed that respondent considered an arterial ischemic event as a possible diagnosis, he believes that respondent erred by failing to prioritize it over the possibility of an acute spinal cord compression.

Dr. Schumb also opined that once signs of an ischemic limb developed, respondent should have consulted with a vascular surgeon regarding P1's symptoms of a vascular occlusion. He also believes that respondent should have updated Dr. Garza about P1's condition; he could not say, however, what Dr. Garza knew about P1's evolving symptoms.

According to Dr. Schumb, when an ED physician requests that a patient be admitted to the hospital, there is no standard of care as to when responsibility for managing a patient's care shifts from the ED physician to the hospitalist. Dr. Schumb's "could not say" when responsibility for managing P1's care shifted from respondent to Dr. Garza, because in his view, every hospital is different.

21. Dr. Lam explained that the job of an emergency physician includes assessing patients for life-threatening conditions, maintaining differential diagnoses, consulting experts, providing treatment, and admitting patients to the hospital as their conditions may require. The standard of care applicable to the transfer of patients from the ED physician to the hospitalist, is that that once the ED physician requests to admit a patient to the hospital, and the hospitalist evaluates the patient and begins writing orders, responsibility for active care and management of the patient shifts to the hospitalist.

Dr. Lam opined that respondent acted within the standard of care in his treatment of P1 for several reasons. Dr. Garza assumed responsibility for the active care and management of P1, at 6:45 p.m., when respondent requested P1's admission to the hospital, Dr. Garza examined her, and was writing orders for her. In Dr. Lam's words, at this time, Dr. Garza "owned" the patient. Thus, in Dr. Lam's view, it was the responsibility of Dr. Garza, and not respondent, to determine the appropriate response to P1's evolving symptoms.[6] This responsibility included prioritizing imaging studies for P1. Dr. Lam noted that Dr. Garza prioritized the MRI over the CT, which is consistent with the diagnostic difficulties presented by this case. The fact that respondent checked in on P1 after Dr. Garza took over P1's care, does not alter Dr. Garza's responsibility for actively managing P1.[7]

Against this background, according to Dr. Lam, whether or not respondent breached the standard of care depends on what actions he took prior to 6:45 p.m. Dr. Lam found that while P1 was under respondent's care, between 5:09 to 6:45 p.m., his treatment of P1 was within the standard of care expected of ED physicians. In drawing this conclusion, Dr. Lam noted that following respondent's initial suspicion of cauda equina, respondent continued to re-evaluate P1's condition.[8] Respondent consulted with Drs. Falk, Garza and Aryanpur; he widened his diagnoses to include the differential diagnoses of spinal cord compression and arterial occlusion; and he ordered MRI's and a CTA[9] to ascertain the presence of one of the

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[6] Dr. Lam also made the point that if at 7:10 p.m., a nurse understood respondent to have directed her to send P1 for the MRI before the CT, the nurse should have known that she was obligated to follow the orders of Dr. Garza, who was responsible for P1's care.

[7] Dr. Lam credited respondent for stopping by P1's bedside to offer her assurances, even after Dr. Garza assumed responsibility for her management and care.

[8] Although the nursing staff was concerned about the lack of pulses in P1's legs when Dr. Wakil was responsible for P1's care, Dr. Lam opined that Dr. Garza's note in her history and physical regarding the presence of a faint distal pulse suggested that Dr. Garza was able to palpate some pulses, and that P1 "had some flow." Dr. Lam also noted that the fact that P1 was successfully re-vascularized shows that P1 did have some blood flow.

[9] Dr. Lam acknowledged that after Dr. Garza assumed management of P1, there "may be some systems issues" to account for the hours it took for P1 to receive the CTA; but he thought it was not fair to hold respondent responsible for this delay. Dr. Lam also was not

two conditions; and he admitted P1 to the hospital for further care and management. In Dr. Lam's view, during the time that respondent was managing P1's care, the standard of care did not require him to prioritize which imaging study should be performed first. Dr. Lam also opined that the standard of care did not require respondent to consult with a vascular surgeon before the CTA results were available; in Dr. Lam's view, such a consultation would have been premature, particularly in a rural area where the availability of consultants is limited.

In concluding that respondent's treatment of P1 was within the standard of care, Dr. Lam also discussed the extremely complex and rare nature of P1's symptoms. According to Dr. Lam, complete aortic occlusion that presents with P1's symptoms is an "extremely rare event" that has significant morbidity and mortality. Because the presentations of cauda equina syndrome and acute aortic occlusion can be easily confused, differentiating between a neurosurgical and a vascular emergency presents a "diagnostic conundrum." In support of his view, Dr. Lam observed that Dr. Sageman noted the unusual nature of P1's presentation; Dr. Aryanpur continued to retain spinal cord compression as a possible diagnosis even after the MRI was performed; and Dr. Aryanpur wanted to wait for the results from the CTA before determining what action should be taken. In analyzing respondent's conduct, Dr. Lam also stressed the importance of viewing P1's diagnostic picture as it emerged, and not "through a retroscope." This is important because physicians who provide emergency treatment do not have the benefit of hindsight to see the patient's ultimate diagnosis. Thus, the fact that P1 was ultimately diagnosed with aortic vascular occlusion should not be relevant in assessing the adequacy of the care provided by respondent to her in the ED.

ULTIMATE FINDINGS RE RESPONDENT'S TREATMENT OF P1

22. Dr. Lam's opinion that respondent acted within the standard of care in his treatment of P1 is more persuasive than Dr. Schumb's. Dr. Schumb opines that by 7:15 p.m., the prospect that P1 suffered from a vascular occlusion should have topped the list of possible diagnosis; and as such, respondent should have prioritized CT imaging and consulted with a vascular surgeon. However, Dr. Schumb's analysis does not address the fact that as of 6:45 p.m., Dr. Garza, and not respondent, was actively managing P1 and was responsible for her care. Additionally, Dr. Schumb's statement that there is no standard of care applicable to the transfer of patients from ED physicians to hospitalists was not persuasive.

In contrast, Dr. Lam's discussion of the standard of care applicable to the transfer of care and management of P1 from respondent to Dr. Garza was persuasive, as was his analysis of the care that respondent provided to P1 before Dr. Garza assumed responsibility for her. Thus, as Dr. Lam concludes, the fact that respondent did not prioritize a CTA over an MRI, or consult with a vascular specialist prior to 6:45 p.m., when Dr. Garza assumed responsibility for P1, was not grossly negligent or repeatedly negligent. And, while respondent did not document that he

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surprised that P1 did not ultimately survive because her disease has a "high morbidity and mortality even with immediate diagnosis."

updated Dr. Garza regarding P1's evolving symptoms, respondent did verbally update Dr. Garza regarding P1's symptoms. In light of Dr. Lam's convincing analysis, it was not proven that respondent's treatment of P1 was either grossly or repeatedly negligent.

Sufficiency of respondent's documentation in P1's medical records

23. Complainant alleges, and respondent admits, that although he performed a history and physical examination of P1, he did not document this examination in P1's medical record. Respondent did, however, document P1's vital signs and medications that he had ordered. Complainant also alleges, and respondent admits, that he failed to include significant facts, such P1's lack of pulse activity and her cold, pale leg, in the medical decision-making section in P1's medical record. Respondent did, however, verbally update Dr. Garza with this information.

24. Respondent explained that the chaotic environment of an ED can impact a physician's record keeping. In P1's case, her condition was in flux and he was consistently at her bedside because he was concerned about her. Although respondent agrees that ultimately he is responsible for ensuring that his documentation is complete, ED physicians at St. Joseph's relied on a "coder" or medical records staff to send them notes if their medical records are incomplete. P1's medical record was not sent back to respondent as being incomplete. Respondent explained that when he used written charts, he never omitted a physical examination, but since the use of electronic records, he estimates that medical records "bounced" back to him on three occasions.

EXPERT OPINIONS AND ULTIMATE FINDINGS RE DOCUMENTATION ERRORS

25. According to Dr. Schumb, the standard of care requires emergency physicians to document the results of a patient's history and physical exam in the patient's medical record and document their medical decision-making. Respondent's failure to include such documentation in P1's medical record constituted inadequate record keeping and a simple departure from the standard of care.

26. Dr. Lam opined that while respondent's records were not complete, his documentation was not inadequate or outside of the standard of care expected of emergency room physicians. In Dr. Lam's view, emergency room physicians are not subject to a standard of care with respect to the adequacy of their documentation, due to the need to quickly stabilize patients. Due to the hectic nature of the work, emergency physicians rely on "coders" or other hospital staff to "kick back" medical records that are incomplete. Dr. Lam concluded that although respondent's records were, in some respects, incomplete, his documentation did not violate the standard of care because P1 received good care.

27. Dr. Schumb's opinion regarding the standard of care regarding documentation was more persuasive than that expressed by Dr. Lam. Although the fast pace of emergency room medicine may mitigate a physician's inadequate documentation, emergency room physicians are not relieved of their duty to maintain adequate and accurate

records. As such, it is found that respondent's failure to document his history and physical examination and update the decision-making section in P1's medical record established that respondent's documentation for P1 was inadequate and inaccurate and constituted a simple departure from the standard of care.

Respondent's treatment of P2

28. As an experienced ED physician, respondent is aware that congestive heart failure (CHF) is a complicated and progressive disease relating to the function of the heart. CHF patients present because their conditions are decompensating, and ED treatment requires everything from a minor to a major intervention. In respondent's experience, CHF patients who present to the ED "overwhelmingly" have abnormal lab values and renal insufficiency.

29. P2, a 77-year-old man, was sent to St. Joseph's ED by his primary care physician (PCP) for elevated liver enzymes and work up for CHF, following P2's complaints of worsening abdominal bloating and leg swelling during the prior two weeks. P2 arrived at the ED on May 16, 2016, at about 6:00 p.m., and was evaluated by respondent at about 7:00 p.m. P2 also reported occasional orthopnea and increased fatigue.

30. P2's history included chronic CHF, myocardial infarction and stents, status post coronary artery bypass, and ischemic cardiomyopathy. P2 was taking furosemide, a diuretic, and spironolactone. P2 had multiple admissions to assess for CHF, and his most recent admission had been one month earlier. Respondent was aware that P2's PCP referred him to the ED, but she did not request that he be admitted to the hospital.

31. Respondent performed a physical examination shortly before 7:00 p.m., and noted normal vital signs, a "pulse ox" level of 98 percent, as well as normal breath sounds. Respondent thought that P2's pulse ox level suggested that his lungs were in proper shape with no significant decompensation. Respondent was, however, concerned about P2's increased liver enzymes, the swelling in his legs, and his abdominal bloating. P2 was not jaundiced.

32. Respondent's evaluation and work up of P2, included the following: P2 was maintained on a cardiac monitor during his stay at the ED, which included taking seven sets of vital signs. Respondent ordered blood work, including a complete blood count, a comprehensive metabolic panel including liver function testing, an EKG, a chest x-ray, and a CT of P2's abdomen and pelvis. The CT revealed minimal fluid in the abdominal cavity. The lab work did not reveal signs of an infection. While the lab results showed that P2 was anemic, it was not so serious as to require treatment in the ED and could be monitored by P2's PCP. P2's lab results revealed an elevated creatinine level and blood urea nitrogen (BUN) level, but respondent did not find these results concerning. P2's creatinine level was high, but not so high that it required dialysis. P2's liver enzymes were also high, but the CT scan of the pelvis and abdomen showed gallstones and minimal ascites, and ruled out an

acute process as the cause. The EKG did not demonstrate ischemia and the chest x-ray revealed that P2's condition had not changed from prior exams.

33. Respondent's work up enabled him to rule out the presence of acute pathology or acute organ dysfunction. After respondent ruled out an acute and life-threatening condition, he concluded that the cause of P2's decompensation was fluid overload. Respondent diagnosed P2 with acute congestive heart failure. Respondent described P2's condition as a mild decompensation.

34. Because fluid overload can lead to congestion, respondent ordered P2 to receive 40 mg of intravenous furosemide. After this treatment, P2 felt much better, and had decreased dyspnea. Respondent instructed P2 to walk around the ED for three to four minutes, which he did. P2's vital signs, including his pulse ox, were also normal. (P2's pulse ox level had increased to 100 percent before his discharge.)

35. Respondent determined that P2 was sufficiently stable to be discharged. P2, however, needed to follow up with his PCP to monitor P2's anemia, renal insufficiency, and liver congestion. Respondent discharged P2 home, consistent with P2's wishes, shortly before 11:00 p.m., with a prescription for furosemide (40 mg, twice daily), and with instructions to follow up with his PCP the following day. Because P2 was a reliable patient who was closely followed by his PCP, respondent expected that P2's lab values would be monitored by his PCP. When he discharged P2, respondent was mindful that the following day was a Tuesday, which would allow P2 to follow up with his PCP.

36. The following day, on May 17, P2's PCP arranged for him to be admitted to the hospital for further evaluation. P2 was not found to have suffered an acute myocardial infarction, and P2 was not given any invasive procedures or testing. P2 received a furosemide drip and was discharged on May 20.

EXPERTS' OPINIONS

37. Dr. Schumb opined that although respondent ordered the appropriate tests for P2, he failed to properly evaluate P2's laboratory tests. For example, Dr. Schumb thought that respondent did not address P2's elevated creatinine levels, which suggested renal insufficiency; and that respondent did not address elevated values relating to liver functioning. Dr. Schumb also believed that respondent should have reviewed P2's earlier laboratory values that showed P2 had developed anemia since January 2016, and that his renal function had declined from his earlier tests. He also criticizes respondent for not considering adjusting the doses of P2's antihypertensive medications and his additional diuretic, which Dr. Schumb believed could exacerbate P2's declining renal functioning. Dr. Schumb also suggests that respondent found P2 to be jaundiced and that he failed to look into this condition further; that respondent failed to address P2's body fluid overload; and, that respondent failed to address P2's borderline oxygen saturation consistent with pulmonary congestion.

Dr. Schumb concludes that respondent was grossly negligent for failing to "recognize the numerous signs of acute end organ dysfunction and impairment, consistent with a significant decompensation of congestive heart failure." Instead of discharging P2, respondent should have obtained a consultation, or admitted P2, to investigate P2's abnormal liver and kidney, and his anemia.

38. According to Dr. Lam, the role of the ED physicians is to assess and diagnose life-threatening conditions and stabilize the patient; it is not to function as a PCP. There are many reasons why a patient with CHF may decompensate, from salt overload or medication noncompliance, to more serious causes. Dr. Lam found that respondent addressed and thoroughly evaluated P2's elevated liver enzymes, abdominal bloating, and lower extremity swelling, which were the reasons he presented to the ED.

In Dr. Lam's view, the data from respondent's work up did not reveal any acute or life-threatening abnormalities. As such, there was no need for any invasive intervention; and consultation or hospitalization was not required. The EKG did not demonstrate acute arrhythmia or heart attack; the chest x-ray revealed that P2's condition had not changed from prior exams; the CT scan of the pelvis and abdomen ruled out any acute process that could lead to increased levels of P2's liver enzymes. P2 did not suffer from a shortage of breath or abnormal lung sounds, and his oxygen saturation was not abnormal. Additionally, Dr. Lam opined that P2's lab values did not require further intervention. Respondent did not need to take further action to address P2's increased creatinine because there was no evidence of acute kidney failure that would require any invasive intervention. Although Dr. Lam found the lab tests related to respondent's liver to be high, it is typical for CHF patients to have high liver enzymes, and respondent's lab values were not "crazy" high. While P2 was anemic, his condition was not so serious as to require a transfusion. Respondent did address P2's fluid overload, which he aggressively treated with a diuretic. (Dr. Lam also referred to this treatment as bolus dosing.) Against this background, respondent's decision to send P2 home with a prescription to increase his outpatient diuretic treatment, with follow up with his PCP the next day, after P2 had been aggressively diuressed and felt better, was reasonable.

In explaining why respondent's decision to discharge P2 was within the standard of care, Dr. Lam observed that there are no clear cut guidelines for hospitalizing CHF patients who present to the ED. In discussing the range of acceptable practices in treating CHF patients who present to ED's, Dr. Lam, quoting Tintanalli's Emergency Medicine, noted the lack of a "readily available and validated ED-based risk stratification tool[s]" for disposition decisions in ED patients with acute heart failure; as such, such decisions are "often based on physician judgment, a physiologic risk assessment, and an assessment of barriers to successful outpatient care such as caregiver support, access to medications, and timely follow up."[10] Additionally, Dr. Lam explained that Tintanalli recommends admitting patients with a

[10] Tintanalli's Emergency Medicine: A Comprehensive Study Guide (8th Ed. 2016) p. 372.

series of high-risk features; and with the exception of P2's elevated BUN level, P2 did not possess any other high risk features suggesting that a hospital admission was necessary.[11]

Dr. Lam also observed that respondent's decision to send P2 home, rather than hospitalize him is supported by the literature, and consistent with a larger effort, by government regulatory bodies, some medical associations, and many hospitals, to avoid unnecessarily hospitalizing CHF patients. Dr. Lam cited a recent article from the Journal of the American College of Cardiology, which found that large numbers of heart failure patients are hospitalized without a clear need for time-sensitive procedures, and estimated that up to 50 percent of heart failure patients who present to ED's could be safely discharged, thereby avoiding unnecessary admissions.[12] In keeping with this trend, Dr. Lam noted that many hospitals have implemented aggressive diuresis with discharge and follow up, as a "quality measure" in the ED. Dr. Lam concluded that respondent's treatment of P2 was well within the standard of care, particularly given the debate in the field as to the proper management and disposition of CHF patients who present to ED's.

ULTIMATE FINDINGS RE TREATMENT OF P2

39. Dr. Lam's opinion that respondent's treatment of P2 was within the standard of care was more persuasive than Dr. Schumb's. Dr. Lam persuasively explained that there is a range of acceptable standards of practice in the management and disposition of CHF patients who present to the ED, and there is currently recognition that many CHF patients who present to the ED are unnecessarily hospitalized. Dr. Lam's analysis of respondent's work up and evaluation, which he also supported with references to the literature, established that respondent took a series of thoughtful actions to rule out the presence of an acute medical condition, and to address the symptoms that P2 presented when he came to the ED. As Dr. Lam explained, respondent's treatment of P2 was within the standard of care because the evaluation and work up confirmed to respondent that the results of P2's lab results, physical exam, CT, x-ray, and EKG, did not present indications of an acute illness. Additionally, respondent took appropriate steps to ensure that P2 could be safely discharged with immediate follow up with his PCP.

Dr. Schumb's analysis of respondent's treatment of P2 was not convincing because the record does not support a conclusion that respondent failed to recognize signs that P2 suffered

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[11] Dr. Lam observed that when P2 was hospitalized on the following day, he did not show evidence of a recent acute coronary syndrome. Dr. Lam also noted that research establishes that the treatment P2 received when he was hospitalized, a furosemide drip, has not shown to produce a greater improvement than bolus dosing.

[12] Collings, Sean, Pang, Peter, et al, "Is Hospital Admission for Heart Failure Really Necessary: The Role of the ED and Observation Unit in Preventing Hospitalization and Rehospitalization," Journal of the American College of Cardiology 2013, (Jan. 2015) 61 (2) pp. 121-126.

from acute end organ dysfunction and impairment that required hospitalization or consultation. Because the data from respondent's work up did not reveal the presence of acute or life-threatening abnormalities, it was not unreasonable for respondent to treat P2 and discharge him with follow up with his PCP. Additionally, Dr. Schumb's discussion of the standard of care applicable to treatment of CHF patients who present to the ED, did not take into account the range of acceptable treatment decisions that exist within this field.

In light of Dr. Lam's persuasive opinion that respondent acted within the standard of care, it was not proven that respondent's treatment of P2 was either grossly or repeatedly negligent.

LEGAL CONCLUSIONS

1. It is complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's Certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App.3d 853, 856.)

2. Unprofessional conduct is grounds for discipline of a physician's Certificate pursuant to Business and Professions Code section 2234. A licensee may be subject to discipline for violating the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), or for committing gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)),[13] or for failing to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

First cause for discipline (P1)

3. By reason of the matters set forth in Factual Findings 21 and 22, the evidence failed to establish that respondent was grossly negligent or repeatedly negligent in his treatment of P1. Cause for license discipline therefore does not exist pursuant to Business and Professions Code section 2234, subdivisions (b) or (c).

4. By reason of the matters set forth in Factual Findings 23, 25, and 27, the evidence established that respondent failed to maintain adequate and accurate medical records for P1. As such, cause for license discipline therefore exists pursuant to Business and Professions Code section 2266, in conjunction with Business and Professions Code section 2234, subdivision (a). Because respondent's record keeping did not amount to gross or repeated negligence, cause for discipline under Business and Professions Code section 2234, subdivisions (b) and (c), does not exist for this misconduct.

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[13] Under the language of the statute, in order to be repeated there must be two or more separate and distinct negligent acts. (Bus. & Prof. Code, § 2234, subd. (c).)

Second cause for discipline (P2)

5. By reason of the matters set forth in Factual Findings 38 and 39, the evidence failed to establish that respondent was grossly negligent or repeatedly negligent in his treatment of P2. Cause for license discipline therefore does not exist pursuant to Business and Professions Code section 2234, subdivisions (b) or (c).

Disciplinary determination

6. Cause for discipline having been established, the issue is the appropriate level of discipline to impose. At the outset, it is noted that the purpose of these proceedings is to protect the public from dishonest, immoral, disreputable or incompetent practitioners and not to punish the respondent. (*Ettinger v. Board of Medical Quality Assurance*, *supra*, 135 Cal.App.3d at p. 856.) Thus, the controlling question is what degree of discipline is necessary to carry out the Board's duty to protect the public?

The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's failure to maintain adequate and accurate records.

It is determined that a public reprimand, pursuant to Business and Professions Code section 2227, subdivision (a)(4), is sufficient to protect the public interest. The facts in the instant case warrant a deviation from the Guidelines for several reasons: The only established basis for discipline, despite the charges in the Accusation, is respondent's record keeping deficiencies. His inadequate documentation involved one patient; and in respondent's long career, his errors appear to be the exception to his usual documentation, rather than the rule. Additionally, respondent acknowledges his inadequate documentation, which is mitigated, but not excused, by the fact that he faced time pressures to provide emergency treatment to his patients, and instead of tending to his documentation, he tended to his patients; and third, this is respondent's first disciplinary matter in his 35 years of practice. Against this background, the protection of the public does not warrant placing respondent's Certificate on probation. In conjunction with his public reprimand, respondent will be required to complete a course in medical record keeping.

ORDER

Respondent Fred William Wakil, M.D is publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). Respondent shall enroll in a course in medical record keeping, approved by the Board, within 60 days from the effective date of this decision, and shall provide proof of his completion of the course no later than six months after his initial enrollment. This course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licenses.

DATED: August 20, 2018

DocuSigned by:
Diane Schneider
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Fred William Wakil, M.D.** **P.O. Box 159** **Bayside, CA 95524-0159** **Physician's and Surgeon's Certificate No. G 49172,** Respondent.	Case No. 800-2016-026609 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On October 25, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number G 49172 to Fred William Wakil, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2018, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code provides that the Board shall have the responsibility for the enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

5. Section 2227 of the Code authorizes the Board to take action against a licensee who has been found guilty under the Medical Practice Act by revoking his or her license, suspending the license for a period not to exceed one year, placing the license on probation and requiring payment of costs of probation monitoring, or taking such other action as the Board deems proper.

6. Section 2234 of the Code states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> . . . .

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTS

8. At all times relevant to this matter, the Respondent was licensed and practicing emergency medicine in California.

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PATIENT P-1[1]

9. Patient P-1, a then 91-year-old woman, was taken by ambulance to the Emergency Department on June 4, 2016 after experiencing sudden severe lower back pain after parking her car and while standing with a friend at the theatre.

10. The Respondent was on duty at the Emergency Department and documented that he saw P-1 at approximately 5:09 p.m. He noted that P-1's pain reportedly radiated to her right leg and was associated with right foot numbness. She was unable to stand due to the severity of the pain. The Respondent further noted that there was no urinary incontinence or saddle anesthesia. In his History of Present Illness (HPI), the Respondent said there was numbness and radiating pain to the patient's legs. In his Review of Systems (ROS), he documented the presence of paresthesia without numbness.

11. There is no documented physical examination in the Respondent's chart notes except for P-1's vital signs, taken at 4:49 and 6:25 p.m. He ordered medication (narcotic and anti-inflammatory analgesics, an anti-emetic, and a steroid) and tests (a complete blood count (CBC), a chemistry study, and a coagulation panel) for P-1.

12. He augmented his chart notes at 6:01 p.m., stating that after his initial evaluation, P-1 had developed bilateral paralysis with loss of sensation in her lower extremities bilaterally, that he had called the neurosurgeon and gotten his answering machine, and that he had cancelled a CT scan and ordered an MRI. His primary impression was lower extremity paralysis and he considered P-1's condition to be critical.

13. The Respondent did not include a significant discussion of his medical decision-making in his Emergency Department chart notes.

14. The nursing staff notified the Respondent that P-1 did not have any pulses in her legs and, at approximately 7:15 p.m., the Respondent re-evaluated P-1 and found that her legs were still warm. Soon thereafter, however, the nursing staff notified the Respondent that P-1's right leg had become cold and pale. The Respondent states that, despite the clinical evidence of vascular

[1] The patients are designated in this document as Patients P-1 and P-2 to protect their privacy. The Respondent knows the identities of the patients and can confirm them through discovery.

occlusion, he did not call the vascular surgeon at that time because he did not have definitive evidence of vascular occlusion. He ordered a CT scan to evaluate P-1 for arterial occlusion in addition to the MRI to evaluate for acute spinal cord emergency.

15. The MRI could not be performed at the hospital and required transport to an off-site outpatient facility. The Respondent had signed P-1 out to the hospitalist for admission to the hospital by the time P-1 was transported to the MRI facility and was no longer on duty. The round-trip transfer and the MRI took three to four hours. The MRI did not show a definitive etiology of P-1's pain.

16. When P-1 returned to the hospital, a CT angiogram was performed. It illustrated a distal aortic vascular occlusion requiring emergent vascular surgery. The three- to four-hour delay for the MRI increased operative mortality.

17. Despite the signs and symptoms of acute vascular ischemia, the Respondent did not order that the CT angiogram, which could have been done at the hospital, be done before the MRI, which required transport to an offsite facility.

18. The Respondent did not document having updated the hospitalist regarding the evidence of acute vascular ischemia when he signed P-1 out to her.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Acts of Negligence and Failure to Maintain Adequate Records)

19. The Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivision (b) (gross negligence) and/or (c) (repeated negligent acts), and 2266 of the Code, in that the Respondent engaged in the conduct described above and below including, but not limited to, the following:

A. The Respondent failed to prioritize imaging of an acute arterial occlusion and to update the hospitalist to whom he had signed Patient P-1 over for admission to the hospital of the evolving symptoms of acute ischemia in Patient P-1's right leg.

B. The Respondent failed to obtain a vascular surgery consult when an ischemic limb was suspected.

C. The Respondent failed to document a physical examination and medical decision-making in his Emergency Department chart.

PATIENT P-2

20. Patient P-2 is a 79-year-old man with a history of congestive heart failure (CHF), ischemic cardiomyopathy, coronary artery disease with myocardial infarction and stents, status post coronary artery bypass, and other serious conditions. He complained of worsening abdominal bloating and leg swelling for the previous two weeks and was sent by his primary care physician on May 16, 2016 to the Emergency Department for evaluation of elevated liver enzymes and to rule out CHF.

21. The Respondent's physical examination of Patient P-2 reflected normal vital signs, including oxygen saturation on room air. He was noted to be +/- icteric (jaundiced) with clear lung sounds and bilateral lower extremity pitting edema. Ascites (abnormal accumulation fluid in the abdominal cavity) was suggested on abdominal examination and confirmed by CT scan. P-2 was anemic with hemoglobin of 8.8; his creatinine was elevated at 2.02 (normal levels are 0.61-1.24), consistent with renal insufficiency; and he had an elevated bilirubin of 3.4 (nl 0.3-1.2), AST of 310 (nl 15-41), ALT of 419 (nl 5-46), BNP of approximately 3000 (nl <100), and an INR of 1.6 (nl 2-3). A CT of the abdomen showed gallstones and minimal ascites. An arterial blood gas indicated borderline hypoxia with an oxygen saturation of 92% on room air.

22. The Respondent gave P-2 40 mg of intravenous furosemide[2], and P-2 felt improved with decreased dyspnea. After several hours in the Emergency Department, the Respondent diagnosed P-2 with acute decompensated congestive heart failure and discharged him with a prescription for furosemide, 40 mg twice daily, and instructions to follow-up with his primary care physician the next day. The Respondent did not document a discussion of the cause of the acute or chronic heart failure decompensation.

[2] Furosemide (trade name Lasix) is a loop diuretic (water pill) that prevents salt absorption, allowing the salt instead to be passed in the urine. Furosemide is used to treat fluid retention (edema) in people with congestive heart failure, liver disease, kidney disorder such as nephrotic syndrome, and high blood pressure.

23. When the Respondent discharged P-2 on 40 mg of furosemide twice daily, he did not adjust P-2's other antihypertensive medications, ramipril and HCTZ.

24. Despite P-2's numerous abnormal laboratory studies, the Respondent did not document a chart review of prior laboratory values. P-2's anemia had developed since his last Complete Blood Count (CBC) in January 2016 when his hemoglobin was 12.5 and his renal function had declined since January and March 2016 when his creatinine was 1.4 and 1.24, respectively.

25. P-2 was admitted directly to the hospital the following day, May 17, 2016, for treatment for exacerbation of his congestive heart failure. During his three-day hospitalization, he lost approximately twenty pounds of water weight.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Acts of Negligence)

26. The Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivision (b) (gross negligence) and/or (c) (repeated negligent acts), of the Code in that the Respondent engaged in the conduct described above including, but not limited to, basing his treatment of Patient P-2 entirely on his respiratory response to furosemide, apparently not recognizing the numerous signs of acute end organ dysfunction and impairment, such as the following, which were consistent with a significant decompensation of congestive heart failure requiring acute hospitalization or consultation:

A. The Respondent noted +/- icterus in his physical examination of Patient P-2 without addressing the markedly elevated transaminases (AST and ALT) and bilirubin which were likely due to hepatic congestion from decompensated congestive heart failure.

B. The Respondent failed to recognize or address P-2's significant anemia which increased the risk of inadequate cardiac perfusion.

C. The Respondent discharged P-2 with an additional diuretic and failed to make or consider dose adjustments of his other antihypertensive medications, which could have further exacerbated his impaired renal perfusion.

D. The Respondent failed to address P-2's borderline oxygen saturation which was consistent with pulmonary congestion.

E. The Respondent did not address P-2's elevated creatinine suggesting that P-2 did not have adequate renal perfusion.

F. Except to administer and prescribe furosemide, the Respondent did not address the likelihood that P-2 was total body fluid overloaded as evidenced by abdominal bloating, lower extremity edema, and ascites.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 49172, issued to Fred William Wakil, M.D.;

2. Revoking, suspending or denying approval of Fred William Wakil, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Fred William Wakil, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: December 5, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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